The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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Attachment 4.19-D

REIMBURSEMENT METHODOLOGY FOR NURSING FACILITIES

The Texas Department of Human Services (TDHS) reimburses Nursing Facility (NF) providers for services provided to eligible recipients in the NF and Swing Bed Hospital programs. The TDHS board determines reimbursement after considering analysis of financial and statistical information and the effect of the reimbursement on achievement of program objectives, including economic conditions and budgetary considerations. Due to the application of the federal Boren Amendment to the NF program, any downward reimbursement adjustment may not exceed the amount of any mark-up or margin over projected costs. This limitation ensures that downward reimbursement adjustments do not reduce reimbursement below the costs which must be incurred by efficient and economic providers meeting federal and state standards.

I. General

A. Uniform Rates. Reimbursement rates are uniform statewide for the same class of service.

B. Prospective Rates. Reimbursement rates are determined prospectively.

C. Unit of Service. The unit of service reimbursed is a day of care provided to a Medicaid client by a Medicaid contracted Nursing Facility. A day is defined as a 24-hr period extending from midnight to midnight.

D. Frequency of Rate Determination. TDHS determines reimbursement rates at least annually.

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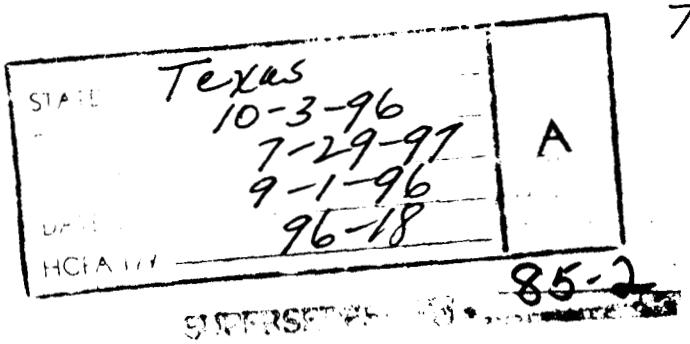
II. Cost Reporting.

A. Cost Reports. In order to ensure adequate financial and statistical information upon which to base reimbursement, TDHS requires that each contracted provider submit an annual cost report and, if necessary, a supplemental report(s). It is the responsibility of the provider to submit accurate and complete information, in accordance with all pertinent TDHS cost reporting rules and cost report instructions, on the cost report and/or any supplemental reports required by TDHS.

B. Pro Forma Costing. When historical costs are unavailable, such as in the case of changes in program requirements, reimbursement will be based on a pro forma approach. This approach involves using historical costs of delivering similar services and determining the types and costs of products and services necessary to deliver services meeting federal and state requirements.

C. Desk Reviews and Field Audits. TDHS conducts desk reviews and field audits of provider cost reports in order to ensure that all financial and statistical information reported in the cost reports conforms to all applicable rules and instructions.

D. Informal Reviews and Appeals. A contracted provider may request an informal review, and subsequently an appeal, of a desk review or field audit disallowance.



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III. Cost Finding Methodology. TDHS adjusts reported expense data using a cost finding methodology to determine per diem allowed costs. TDHS makes certain adjustments to ensure that costs used for rate projections are required for long term care, derived from the marketplace, and incurred from economic and efficient use of resources.

A. Cost determination by cost area. Effective September 1, 1990, TDHS combines adjusted expenses (A.1. and A.2. below) and other pertinent data (A.3. below) from the rate base to determine three cost-related components.

1. Recipient Care cost component. The recipient care cost component includes all direct recipient care expenses, including nurse and nurse aide salaries, payroll taxes and employee benefits; consultant fees; social and activity services and training expenses; laundry and housekeeping expenses; medical supplies; and durable medical equipment.

2. General, Administrative and Dietary cost component. Effective September 1, 1990, this cost area consists of:

a. general operations costs, including transportation and departmental equipment; taxes and insurance; utilities; maintenance personnel salaries, payroll taxes and employee benefits; and other plant operation and maintenance expenses;

b. administrative costs, including administrative salaries, payroll taxes and employee benefits; supplies; interest on working capital; and home office overhead expenses; and

c. dietary costs, including food; utensils and supplies; food service salaries, payroll taxes and employee benefits; and consultant expenses.

3. Fixed Capital Asset component. Fixed capital charges are based on the most recent appraised value of facilities, including land and improvements, as determined by the most recent assessment of the local taxing authority and reported on the cost report. Tax exempt facilities not provided an appraisal from their local taxing authority because of an exempt status must contract with an independent appraiser to appraise the facility land and improvements.

B. Exclusion of Certain Reported Expenses. Providers are responsible for eliminating all unallowable expenses from the cost report. TDHS reserves the right to exclude any unallowable expenses from the cost report and to exclude entire cost reports from the data base if it is believed that the cost reports do not reflect economic and efficient use of resources.

1. Fixed Capital Asset Charges. Effective September 1, 1990, fixed capital asset costs are reimbursed in the form of a Use Fee calculated as described under section (IV)(B)(1). Consequently, [illegible] fixed capital asset charges are excluded from the rate base for purposes of calculating the General, Administration and Dietary Cost Area component: building and building equipment depreciation and lease expense; mortgage interest; land improvement depreciation; and leasehold improvement amortization.

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C. Adjustments to Certain reported Expenses. TDHS makes adjustments to the expenses reported by providers to ensure that expenses used in rate determination are required for long term care, derived from the market place and incurred from economic and efficient use of resources.

1. Limits on certain administration costs. To ensure that the results of TDHS's cost analyses accurately reflect the costs that an economic and efficient provider must incur, TDHS limits related-party facility administrator and owner salary, wages, and/or benefits to a cap based on the 90th percentile of nonrelated party administrator salaries, wages, and/or benefits. TDHS limits related-party assistant administrator salary, wages, and/or benefits to a cap based on the 90th percentile of nonrelated party assistant administrator salaries, wages, and/or benefits.

2. Occupancy adjustments. TDHS adjusts the facility and administration costs of providers with occupancy rates below a target occupancy rate. The target occupancy rate is the lower of (a) 85 percent or (b) the overall average occupancy rate for contracted beds in facilities included in the rate base during the cost reporting periods included in the rate base. For each provider whose occupancy falls below the target occupancy rate, an adjustment factor is calculated as follows: adjustment factor = 1.00 - (provider's occupancy rate / appropriate target occupancy rate). This adjustment factor is then multiplied by each cost line item in the facility and administration cost areas of the cost report, and the result of this calculation is subtracted from the line item amount.

D. Projected Costs. TDHS determines reasonable methods for projecting each provider's costs to allow for significant changes in cost-related conditions anticipated to occur between the historical cost reporting period and the prospective rate period. Significant conditions include, but are not limited to, wage and price inflation or deflation, changes in program utilization and occupancy, modification of federal or state regulations and statutes, and implementation of federal or state court orders and settlement agreements.

1. General Cost Inflation Index. TDHS uses the Implicit Price Deflator-Personal Consumption Expenditures (IPD-PCE) as the general cost inflation index. The IPD-PCE is a nationally recognized measure of inflation published by the Bureau of Economic Analysis of the U.S. Department of Commerce. To project or inflate costs from the reporting period to the prospective reimbursement period, TDHS uses the lowest feasible IPD-PCE forecast consistent with the forecasts of nationally recognized sources available to TDHS at the time proposed reimbursement is prepared for public dissemination and comment.

2. Item-specific and Program-specific inflation indices. TDHS shall use specific indices in place of the general cost inflation index when appropriate item-specific or program-specific cost indices are available from TDHS cost reports or other surveys, other Texas state agencies or independent private sources, or nationally recognized public agencies or independent private firms, and TDHS has determined that these specific indices are derived from information that adequately represents the program(s) or cost(s) to which the specific index is to be applied. Nursing wages are inflated by wage inflation factors based on wage and hour survey information submitted on cost reports or special surveys, Social Security payroll taxes are inflated by FICA inflation factors based on data obtained from the Statistical Abstract of the United States, and federal and state unemployment taxes are inflated by FUTA/SUTA inflation factors based on data obtained from the Texas Workforce Commission.

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IV. Rate Setting Methodology.

(A) Case mix classes. TDHS reimbursement rates vary according to the assessed characteristics of recipients. Rates are determined for 11 case-mix classes of service, plus a twelfth, temporary classification assigned by default when assessment data are incomplete or in error.

(B) Reimbursement determination.

(1) Rate components. Under the case mix methodology, rates are comprised of three cost-related components: the Recipient Care component; the General, Administration, and Dietary component; and the Fixed Capital Asset Use Fee component.

(a) The Recipient Care rate component varies according to the case mix class of service and is discussed in (IV)(B)(3).

(b) The General, Administration, and Dietary component is constant across all case mix classes. This component is calculated at the median point in the array of projected allowable per diem costs for all contracted nursing facilities included in the rate base, multiplied by 1.07.

(c) The Fixed Capital Asset component is calculated as follows:

(i) Determine the eightieth percentile in the array of allowable appraised property values per licensed bed, including land and improvements. Appraised values for this purpose are determined by the most recent appraisal available from the local taxing authority and reported on the Texas Medicaid cost report. Tax exempt facilities not provided an appraisal from their local taxing authority because of an exempt status must contract with an independent appraiser to appraise the facility land and improvements. Facilities not reporting an appraised property value are not included in the array for purposes of calculating the use fee.

(ii) Project the eightieth percentile of appraised property values per bed by one-half the forecasted increase in the Implicit Price Deflator for Personal Consumption Expenditures (IPD-PCE) from the cost reporting year to the rate year.

(iii) Calculate an annual use fee per bed as the projected eightieth percentile of appraised property values per bed times an annual use rate of fourteen percent.

(iv) Calculate a per diem use fee per bed by dividing the annual use fee per bed by annual days of service per bed at the higher of 85 percent occupancy, or the statewide average occupancy rate during the cost reporting period.

(v) For rates effective January 1, 1991, and thereafter, the use fee is limited to the lesser of (a) the fee as calculated in (IV)(B)(1)(c)(i)-(iv) above, or (b) the fee as calculated by inflating the fee from the previous rate period by the forecasted change in the IPD-PCE.

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2. Case mix classification system. All Medicaid recipients are classified according to the Texas Index for Level of Effort (TILE) classification system. The TILE classification system includes four clinical categories, which are further subdivided on the basis of an Activity of Daily Living (ADL) scale, resulting in a total of 11 TILE case mix groups. A twelfth group is used by default when a recipient's case mix group membership is indeterminate because of assessment errors or omissions. The default group is paid at the lowest case mix rate until TILE assessment data are available in the payment system. Each of the eleven case mix groups is assigned a case mix index of effort. This index reflects the relative amount of direct and indirect care time, on average, devoted by direct care personnel to recipients in each group.

3. Per diem rate methodology. Staff determine per diem rate recommendations to the DHS Board for each of the eleven TILE groups and for the default group. The DHS Board review and approves the reimbursement rates for each TILE group to determine reimbursement rates which will reasonably reimburse the costs of an economic and efficient provider. Rates are determined according to the following procedures:

a. Determine the statewide average case mix index for all Medicaid recipients, except those in the default group. Weight the indexes from (IV)(B)(2) above, which are based on a **sample** of nursing facilities, by estimated **statewide** recipient days of service by case mix group during the cost reporting period covered by the rate base. In determining rates effective January 1, 1992, and thereafter, the statewide average index is based on the most recent and complete data available indicating recipient days of service by case mix group which correspond to the period covered by the cost reports included in the rate base. Since reasonably complete data on days of service by case mix group corresponding to complete cost reporting periods are not available for periods prior to fiscal year 1990, rates effective prior to January 1, 1992, are based on an average case mix index determined as follows:

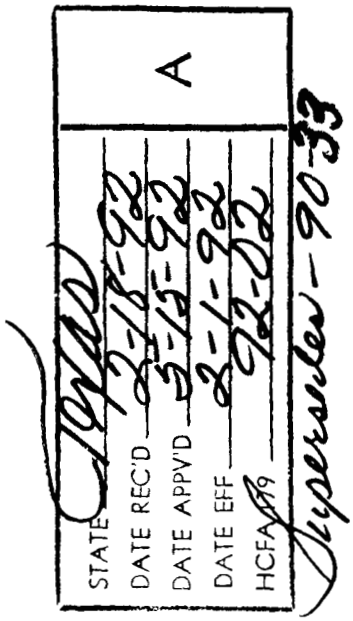
(i) Rates effective September 1, 1990, are based on the same distribution of days of service by case mix group used to determine the initial case mix rates effective April 1, 1989, through December 31, 1989.

(ii) Rates effective January 1, 1991, through December 31, 1991, are based on the most recent and complete data available indicating days of service by case mix group during the period April 1, 1989, through June 30, 1989.

b. Calculate standardized statewide case mix indexes. Determine the standardized statewide case mix index for each of the 11 TILE groups by dividing each of the indexes described under (IV)(B)(2) above by the statewide average case mix index described under (IV)(B)(3)(a).

c. Determine average recipient care rate component. To determine the average recipient care rate component, adjust the raw sum of recipient care costs in all nursing facilities included in the rate base in order to account for disallowed costs and inflation, as specified under (III). Then divide the adjusted total by the sum of recipient days of service in all facilities in the current rate base. Multiply the resulting weighted, average per diem cost of recipient care by 1.07. The result is the average recipient care rate component.

d. Case mix recipient care per diem rate components. To calculate the recipient care per diem rate component for each of the 11 TILE case mix groups and for the default group, multiply each of the standardized statewide case mix indexes from clause (IV)(B)(3)(b) by the average recipient care rate component from (IV)(B)(3)(c) above.



e. Total case mix per diem rates. For each of the 11 TILE case mix groups and for the default group, the recommended total per diem rate is the sum of the following three rate components:

(i) the case mix recipient care per diem rate component by case mix group from (IV)(B)(3)(a)-(d) above;

(ii) the general, administration and dietary rate component from (IV)(B)(1)(b) above; and

(iii) the fixed capital asset use fee component from (IV)(B)(1)(c) above.

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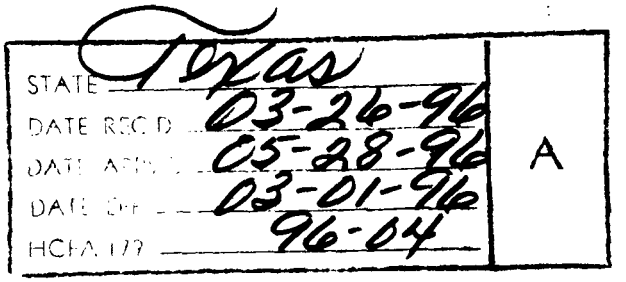
f. Supplemental reimbursement for ventilator-dependent residents. Qualifying residents receive a supplement to the per diem rate specified in (IV)(B)(3)(e) above.

(i) To qualify for supplemental reimbursement, a resident must require artificial ventilation for at least 6 consecutive hours daily and the use must be prescribed by a licensed physician.

(ii) A ventilator-dependent resource differential case mix index is calculated, based on time-study research data. This resource differential index reflects the difference between direct nursing services for ventilator-dependent residents and services for residents in the most severe heavy-care TILE group. The per diem rate supplement is calculated by multiplying the resource differential case mix index times the per diem average recipient care rate component, as described in (IV)(B)(3)(c) above.

(I) The supplemental reimbursement for residents requiring continuous artificial ventilation is 100% of the per diem ventilator rate supplement.

(II) The supplemental reimbursement for residents not requiring continuous artificial ventilation daily but requiring artificial ventilation for at least 6 consecutive hours daily is 40% of the per diem ventilator rate.



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